REFERENCES

Blaney, T., and Craig, R.J., 1999. Methadone maintenance: Does dose determine differences in outcome? *Journal of Substance Abuse Treatment* 16(3):221-228.

Caplehorn, J.R.M.; Lumley, T.S.; and Irwig, L., 1998. Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence* 52(1):57-61.

Chutuape, M.A.; Silverman, K.; and Stitzer, M.L., 1999. Use of methadone take-home contingencies with persistent opiate and cocaine abusers. *Journal of Substance Abuse Treatment* 16(1):23-30.

Condelli, W.S., 1993. Strategies for increasing retention in methadone programs. *Journal of Psychoactive Drugs* 25(2):143-147.

D'Aunno T.; Folz-Murphy, N.; and Lin, X., 1999. Changes in methadone treatment practices: Results from a panel study, 1988-1995. *American Journal of Drug and Alcohol Abuse* 25(4):681-699.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2001. 21 CFR Part 291, 42 CFR Part 8. Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction; Final Rule. *Federal Register* 66(11):4075-4102, January 17, 2001.

Ducharme, L.J., and Luckey, J.W., 2000. Implementation of the methadone treatment quality assurance system. Findings from the feasibility study. *Evaluation and the Health Professions* 23(1):72-90.

Joe, G.W.; Simpson, D.D.; and Hubbard, R.L., 1991. Treatment predictors of tenure in methadone maintenance. *Journal of Substance Abuse* 3(1):73-84.

Maddux, J.F.; Prihoda, T.J.; and Vogtsberger, K.N., 1997. The relationship of methadone dose and other variables to outcomes of methadone maintenance. *American Journal on Addiction* 6(3):246-255.

Magura, S.; Nwakeze, P.C.; Kang, S.; and Demsky, S., 1999. Program quality effects on patient outcomes during methadone maintenance: A study of 17 clinics. *Substance Use & Misuse* 34(9):1299-1324.

Magura, S.; Nwakeze, P.C.; and Demsky, S.Y., 1998. Pre- and in-treatment predictors of retention in methadone treatment using survival analysis. *Addiction* 93(1):51-60.

Saxon, A.J., et al., 1996. Pre-treatment characteristics, program philosophy, and level of ancillary services as predictors of methadone maintenance treatment outcome. *Addiction* 91(8):1197-1209.

Simpson, D.D., and Sells, S.B., 1982. Effectiveness of treatment for drug abuse: An overview of the DARP research program. *Advances in Alcohol and Substance Abuse* 2:7-29.

Ward, J.; Mattick, R.P.; and Hall, W., 1998. How Long Is Long Enough? Answers to Questions About the Duration of Methadone Maintenance Treatment. In J. Ward, R.P. Mattick, and W. Hall (eds.), *Methadone Maintenance Treatment and Other Opiate Replacement Therapies*. Amsterdam: Harwood Academic Publishers, pp. 305-336.

RESPONSE: THE NEW ENVIRONMENT OF ACCOUNTABILITY FOR OTPS

R. Lorraine Collins, Ph.D., William Cornely, M.H.S., and Christine Grella, Ph.D.

When researchers work with treatment providers, our methods have to be objective, but we also want the treatment to be successful, and partnership is important for that reason.

Lorraine Collins: The demand for accountability is ratcheting up. Methadone programs may find themselves having to be increasingly accountable.

William Cornely: With respect to retention of patients in opioid treatment, most drug-free programs have already made the transition to viewing the patient as a customer who must be retained, and their experience may be helpful to methadone programs.

What other outcomes, besides retention, should be considered for accountability? For example, what about having someone off methadone in a year or 2 years, or having lower incidence of AIDS?

Christine Grella: Ideally, methadone programs would target a range of outcomes, including use of opioids and other drugs, alcohol use, and then issues such as housing, unemployment, and general psychosocial functioning. A troubling issue that I saw first-hand while working on a study in a methadone clinic is that much of the patients' ability to respond to treatment was related to issues in their communities and to things like whether they continued to live with a substance abuser. These environmental issues are a huge determinant of outcomes and completely beyond our control.

Grella: Jackson's call for partnership—informing the treatment staff of current research and inviting researchers to work with providers in testing different approaches to improving delivery of treatment—is excellent. He is absolutely right, too, in saying we need more research on how organizations can change to implement different treatment practices. A potential research question would be, 'What program characteristics are associated with the ability to implement effective practices?' Jackson cites one example: a study showing that attitudes and experiences of program directors in methadone programs made a difference.

Collins: Many programs have staff members who work there because of their experiences recovering from substance abuse and who have an understandable bias toward whatever treatment regimen was successful for

them. Those perspectives are now being challenged or questioned by the emphasis on accountability. In the future, treatment personnel may have to come from other backgrounds, with professional rather than experiential training. Research might look at the question, 'How well are staff members with each kind of background able to perform as drug abuse treatment providers?'

Grella: I was intrigued with the author's suggestion that the research community can give more guidance on different ways to train the program staff. I think this is especially important in OTP facilities where the staff—especially those who have worked a long time—may have strong beliefs about how effective the treatment is and what they can accomplish with the patients they see. We really need to test different approaches to working with staff members to upgrade their skills and deal with their resistance to change.

Collins: The use of treatment manuals and other materials to disseminate actual treatment protocols is going to be crucial for raising the level of staff knowledge. The large multisite research studies are already starting to do this. The manuals walk practitioners through the study protocols step by step. For example, here is a new assessment instrument, here is how you score it, here are some ways of intervening with patients with each possible score.

To some extent, I think Jackson sees researchers as able to do more than we actually can. Researchers will not be able to influence all the State regulations and policies that affect credentialing. With respect to salary structures, we will not be able to do much beyond saying that with better education and better pay, you might have a more effective staff. As to the issue of enhancing the ability of agencies to perform survival analysis, even universities have difficulty finding staff to do survival analysis.

Grella: When researchers work with treatment providers, our methods have to be objective, but we also want the treatment to be successful, and partnership is important for that reason.

Cornely: This issue of noncompliant—for lack of a better word—patients is one that programs grapple with all the time. When you have to make a decision about keeping someone in treatment who continues to use drugs, especially in drug-free treatment, you walk a fine line between maintaining the integrity of the program and helping the individual. In our program we will usually retain a patient who uses drugs and help them get through the relapse, intensify services, and those sorts of things. Some other programs are very rigid: If you use, you are kicked out.

Generally, the belief is that good treatment means increasing treatment, rather than withdrawing it, when patients continue to use or relapse. Jackson suggests that a wider range of treatment options might be the answer for some nonresponding individuals. We can certainly design a study where we have different levels of intensity—high, enhanced, etc. But given the reality in which these programs function, with their limited resources, how are they going to implement the programs?

Ideally, methadone programs would target a range of outcomes, including issues such as housing, unemployment, and general psychosocial functioning.

Grella: The research is very clear that individuals in methadone therapy who use cocaine or alcohol have relatively poor response to treatment. We can design studies to look at cocaine-reduction protocols in methadone programs, but the degree to which community OTPs can implement them is going to vary widely. We keep coming back to the issues of resources and feasibility.

Collins: A lot of programs aren't focusing enough on mental health issues as they relate to substance abuse. Maybe someone is not responding well to methadone because of other psychiatric problems that are not being addressed by the program. We probably need broader assessments. Research can definitely help with that. One research-based model is [Prochaska and Di Clemente's] 'Stages of Change,' which has been applied to drug abuse. Stages of Change looks at where people are along a continuum that goes from precontemplation [not really considering the life changes that treatment will require], through contemplation [of committing to the changes], to action, and so on. If somebody is in the precontemplation stage, it's not the right time to jump into treatment, but there might be some other activities he or she could engage in to move the process along. &